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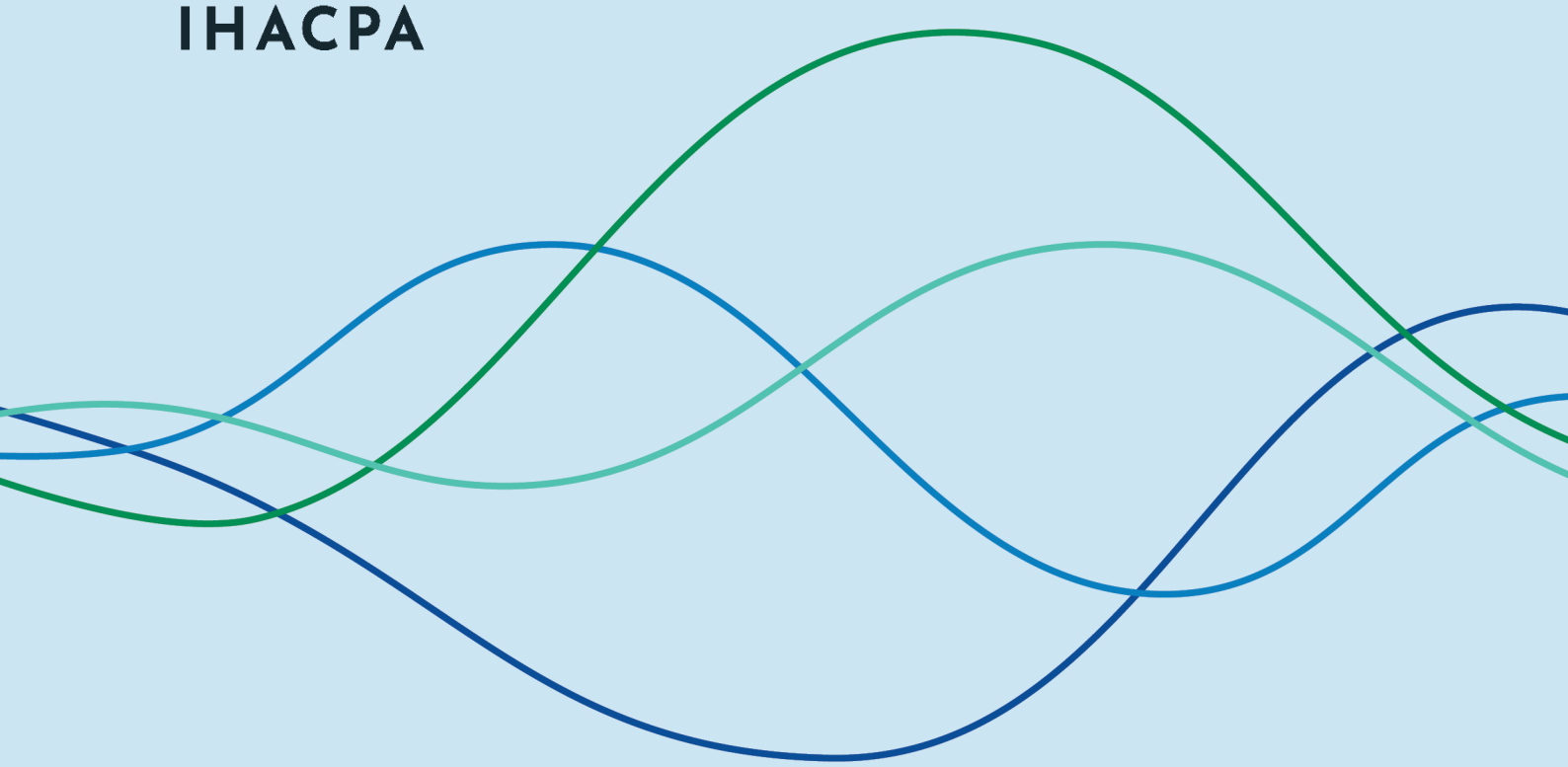

Pricing Framework for Australian Public Hospital Services 2026–27

Consultation report

December 2025

Independent Health and Aged Care Pricing Authority

Pricing Framework for Australian Public Hospital Services 2026–27 — Consultation Report December 2025

Contents

Abbreviations

Abbreviation	
ABF	Activity based funding
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
ADRG	Adjacent Diagnosis Related Group
AECC	Australian Emergency Care Classification
AHPCS	Australian Hospital Patient Costing Standards
AHR	Avoidable hospital readmission
AIHW	Australian Institute of Health and Welfare
AMHCC	Australian Mental Health Care Classification
ANAPP	Australian Non-Admitted Patient Classification Project
AN-SNAP	Australian National Subacute and Non-Acute Patient Classification
AR-DRG	Australian Refined Diagnosis Related Group
CALD	Culturally and linguistically diverse
COVID-19	Coronavirus disease 2019
EBA	Enterprise bargaining agreement
ED	Emergency department
EVC	Emergency virtual care
HAC	Hospital acquired complication
HDU	High-dependency units
HST	Highly specialised therapy
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
ICU	Intensive care unit

ICT	Information and communication technology
IFR	Independent Financial Review
IHACPA	Independent Health and Aged Care Pricing Authority
LHN	Local hospital network
LSP	Life Skills Profile
MBU	Mother baby unit
MDC	Major Diagnostic Category
NBP	National Benchmarking Portal
NMDS	National Minimum Data Set
NEC	National efficient cost
NEP	National efficient price
NDIS	National Disability Insurance Scheme
NHCDC	National Hospital Cost Data Collection
NHFB	National Health Funding Body
NHRA	National Health Reform Agreement
NWAU	National weighted activity unit
PBS	Pharmaceutical Benefits Scheme
The addendum	Addendum to the National Health Reform Agreement 2020–26
The Commission	Australian Commission on Safety and Quality in Health Care
The NHR Act	The *National Health Reform Act 2011*
The pricing framework	The Pricing Framework for Australian Public Hospital Services 2026–27
Tier 2	Tier 2 Non-Admitted Services Classification
VAD	Voluntary assisted dying

1

Introduction

1. Introduction

1.1 About IHACPA

The Independent Health and Aged Care Pricing Authority (IHACPA) was established under the National Health Reform Act 2011 (the NHR Act) to improve health outcomes for all Australians.

IHACPA enables the implementation of national activity based funding of public hospital services through the annual determination of the national efficient price (NEP) and national efficient cost (NEC). These determinations play a crucial role in calculating the Commonwealth funding contribution to Australian public hospital services and offer a benchmark for the efficient cost of providing those services as outlined in the National Health Reform Agreement (NHRA).

1.2 About this consultation report

The Pricing Framework for Australian Public Hospital Services is one of IHACPA's key policy documents and underpins the approach adopted by IHACPA to determine the NEP and NEC for Australian public hospital services.

IHACPA conducted a public consultation on the key issues to be included in the Pricing Framework for Australian Public Hospital Services 2026–27 (the pricing framework) through the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2026–27.

The consultation period ran from 14 May 2025 to 13 June 2025. IHACPA invited submissions from the Australian Government, state and territory health departments, professional health organisations, the private health industry and other interested members of the Australian public.

IHACPA received 30 submissions to the consultation paper from a diverse range of stakeholders. Key themes arising from the consultation feedback are summarised in this report, corresponding with the chapters in the pricing framework. This stakeholder feedback has informed the development of the pricing framework, including the decisions that underpin the NEP Determination 2026–27 (NEP26) and NEC Determination 2026–27 (NEC26).

IHACPA has included some of its own general feedback within this report and will respond to stakeholders directly where specific issues were highlighted relevant to that organisation. IHACPA will consider any feedback provided outside the specific areas of consultation as part of its relevant work program. The key decisions for NEP26 and NEC26 are outlined in the pricing framework.

All submissions have been made available on IHACPA's Engagement Hub, unless they were marked confidential for commercial or other reasons.

Development of the next addendum to the NHRA

IHACPA notes that the Addendum to the NHRA 2020–25 was amended and extended in February 2025 through the signing of Schedule K by Australian governments. This extension, now referred to as the Addendum to the NHRA 2020–26 (the addendum), applies from 1 July 2025 to 30 June 2026.

IHACPA recognises that the development of the next addendum to the NHRA is underway and may introduce changes or new provisions with significant implications for the national pricing model. These could affect how the NEP and NEC are developed and potentially support alternate funding models for specific cohorts.

As decisions regarding the next addendum are yet to be finalised, the national pricing model underpinning NEP26 and NEC26 will continue to be based on the requirements set out in the NHR Act and the addendum. Once agreed, the implications of a new addendum for future determinations will be considered in consultation with stakeholders.

2

Pricing Guidelines

2. Pricing Guidelines

2.1 The Pricing Guidelines

Question 1.

Are stakeholders supportive of revising the promoting harmonisation Pricing Guideline to: "Promoting harmonisation: Pricing should facilitate best practice provision of equivalent care across appropriate settings, sites and modalities"?

Feedback received

Stakeholders broadly supported the proposed revision to the promoting harmonisation Pricing Guideline. The revised wording was seen as a positive step toward enabling the delivery of virtual care across appropriate settings, supporting innovation in service delivery, and promoting equity in access to care.

The Australian Capital Territory (ACT) noted that services undergoing harmonisation should be assessed on a case-by-case basis. Victoria (Vic), Advanced Pharmacy Australia, Catholic Health Australia (CHA), and the Human Genetics Society of Australasia (HGSA) emphasised the importance of accounting for specialty-specific clinical factors and the true costs associated with multidisciplinary care.

Vic, Western Australia, the Northern Territory, ACT, CHA, the Rural Doctors Association of Australia, and the Australian College of Rural and Remote Medicine called for clearer definitions within the Pricing Guidelines, particularly regarding the terms "appropriate settings, sites and modalities." These stakeholders also suggested that the Guidelines more explicitly recognise cost variations in rural and remote areas, the implications of an ageing population, and the importance of equity and access in pricing design.

IHACPA's response

The Independent Health and Aged Care Pricing Authority (IHACPA) notes that the proposed revision received broad support and will implement this change in the Pricing Guidelines for 2026–27. IHACPA acknowledges the challenges associated with undertaking price harmonisation and will continue to review and refine its price harmonisation methodology in consultation with its advisory committees.

The Pricing Guidelines outline the overarching process and system design guidelines within which IHACPA makes its policy decisions. IHACPA considers the other existing Pricing Guidelines sufficiently account for the issues raised and does not propose any changes to the Pricing Guidelines for 2026–27. The Pricing Guideline of fairness recognises the legitimate and unavoidable costs faced by providers of public hospital services, including those operating in a rural or remote setting and that activity based funding payments should be fair and equitable. The Pricing Guideline of evidence-based dictates that all pricing models should be based on current evidence, such as evidence of the clinical and cost impacts of population changes. Once the next addendum to the National Health Reform Agreement is finalised, IHACPA will undertake a comprehensive review of its Pricing Guidelines.

3

Classifications used to describe and price public hospital services

3. Classification used to describe and price public hospital services

3.1 Admitted acute care

Australian Refined Diagnosis Related Groups Version 12.0

Question 2.

What, if any, barriers are there to pricing admitted acute episodes of care using Australian Refined Diagnosis Related Groups (AR-DRG) Version 12.0 without a shadow pricing period for the National Efficient Price Determination (NEP) 2026–27 (NEP26)?

Feedback received

South Australia (SA), the Northern Territory (NT), the Australian Capital Territory (ACT), Catholic Health Australia (CHA), and the Queensland Nurses and Midwives' Union (QNMU) recommended shadow pricing to manage risks associated with changes in clinical coding, better anticipate financial and operational impacts, maintain data stability, and minimise variances that could affect NEP26. NT emphasised that shadow pricing supports equity, particularly for smaller states and territories more vulnerable to pricing fluctuations.

In contrast, New South Wales (NSW), Victoria (Vic), Queensland (Qld), Western Australia (WA), and the Human Genetics Society of Australasia (HGSA) did not identify barriers to implementing AR-DRG Version 12.0 without a shadow pricing period, citing minimal structural changes and alignment with previous implementations. Qld noted an expectation that changes would be back-cast to align with the updated classification. CHA proposed that the Independent Health and Aged Care Pricing Authority (IHACPA) release a detailed explanation of pricing changes for admitted acute care alongside the launch of AR-DRG Version 12.0 in July 2025, supported by targeted education through IHACPA Learn to ensure stakeholders can effectively interpret and apply the changes.

HGSA proposed including posthumous blood or tissue collection for future genetic testing under Adjacent Diagnosis Related Group (ADRG) A16 *Posthumous organ procurement*. Additionally, stakeholders sought guidance on the classification of device-intensive procedures and confirmation that real-world device costs, such as those associated with cardiac technologies, are appropriately captured.

Stakeholders from the private hospital sector and clinical specialties raised concerns that the AR-DRG classifications do not adequately reflect service complexity or funding equity. The Australian Society of Plastic Surgeons (ASPS) and the Australian Dental Association (ADA) highlighted inaccuracies affecting plastic and reconstructive surgery and dental procedures, leading to funding discrepancies. ADA also noted that dental procedures are often deprioritised in private hospitals due to pricing incentives. ASPS further called for mandatory adoption of updated AR-DRG classifications in private hospitals to ensure consistent and equitable funding across sectors.

IHACPA's response

IHACPA intends to implement AR-DRG Version 12.0 for NEP26 without a shadow pricing period. This is consistent with IHACPA's National Pricing Model Consultation Policy and Shadow Pricing Guidelines, under which shadow pricing is only required for major structural changes or new data elements. Impact analysis has been provided to jurisdictions to demonstrate pricing changes between AR-DRG Version 11.0 and Version 12.0. Back-casting volume multipliers will be produced to support the transition. Concerns about equity during transition are noted, but shadow pricing does not guarantee protection from disadvantage.

IHACPA intends to continue to allocate posthumous organ procurement costs to transplant episodes for NEP26. Future pricing of the new ADRG A16 *Posthumous organ procurement* will be informed by the findings of IHACPA's review of organ and tissue donation, retrieval and transplantation activity and analysis of cost data. IHACPA notes that in-scope blood and tissue collection and device costs should continue to be reported against the relevant care episode to support pricing accuracy.

IHACPA has released educational materials to support the implementation of AR-DRG Version 12.0. However, these materials focus on classification changes and do not include explanations of pricing changes. Stakeholders seeking pricing information should refer to the documentation published as part of the annual NEP determinations.

IHACPA sees no current evidence of inaccuracies in the AR-DRGs for plastic and reconstructive surgery, noting that classifications reflecting Medicare Benefits Schedule updates for breast reconstruction were implemented on 1 July 2025.

IHACPA does not oversee private hospital practices but encourages use of the latest AR-DRG versions in agreements and notes IHACPA's support for versions prior to Version 9.0 has ceased.

3.2 Subacute and non-acute care

IHACPA did not ask any specific consultation questions on the subacute and non-acute care classifications but received feedback from a small number of stakeholders on this area.

Feedback received

NSW endorsed the proposed horizon scan or literature review and exploration into the use of Frailty Related Index of Comorbidities and alternative tools for assessment of frailty.

SA supported refinements for patients awaiting aged care or National Disability Insurance Scheme (NDIS) support and suggested further review of the non-acute care classification. SA proposed distinguishing short-stay non-acute episodes focused on stabilisation from longer-term maintenance care to improve classification accuracy.

IHACPA's response

IHACPA will price subacute and non-acute services using the Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) Version 5.0 for NEP26 and continue with the development of AN-SNAP Version 5.1. This will include a review of frailty measures and treatment of maintenance care patients awaiting aged care or NDIS support.

3.3 Emergency care

IHACPA did not ask any specific consultation questions on the emergency care classifications but received feedback from one stakeholder on this area.

Feedback received

NSW recommended consideration of the increased complexity of patients with secondary diagnoses such as mental health and/or alcohol and other drug-related concerns.

IHACPA's response

IHACPA recognises the need to continue to make improvements in how the Australian Emergency Care Classification (AECC) accounts for patient complexity over time. As part of the AECC Version 2.0 refinement, IHACPA investigated incorporation of additional diagnosis in the AECC complexity model. Although some patient administrative systems have capability to capture additional diagnoses, actual reporting of additional diagnoses through the emergency care data collections remains low. As such, IHACPA is unable to further investigate inclusion of additional diagnoses in the AECC until data reporting improves.

3.4 Non-admitted care

3.4.1 Australian Non-admitted Patient Classification Project (ANAPP)

IHACPA did not ask specific consultation questions on the ANAPP and the development of the new non-admitted care classification but received feedback from a small number of stakeholders on this area.

Feedback received

NSW recommended that IHACPA consider implementing additional, targeted data collections during Stage 3 of the ANAPP to support statistically representative sampling and robust analysis of cost impacts related to service delivery, models of care, workforce mix, and patient characteristics. Qld raised concerns about the complexity of abstracting unstructured clinical documentation from medical records, particularly in facilities without electronic medical records, and suggested that an alternative interim dataset may be necessary. CHA highlighted the importance of engaging the private hospital sector in the refinement of classifications used to describe and price public hospital services, to ensure their applicability across the broader health system.

IHACPA's response

IHACPA is currently conducting Stage 2 of the ANAPP, which incorporates a large data extraction and costing study. IHACPA continues to consult closely with its working groups and advisory committees on Stage 3 of the ANAPP, with ongoing consideration of how states and territories, in addition to Qld and Vic, can meaningfully contribute to the data set.

IHACPA's advisory committees and working groups include key stakeholders from the private hospital sector. IHACPA has distributed an out of session paper to members outlining the case mix spread across metro and regional locations and classifications of care. IHACPA will continue to consult with these stakeholders in the refinement and development of classifications.

Following the completion of the ANAPP, IHACPA will work with state and territory governments to ensure a new non-admitted classification is fit-for-implementation, including considering concerns around current data collection practices.

3.4.2 Tier 2 Non-Admitted Services Classification

Question 3.

Are there any other refinement areas IHACPA should consider for the Tier 2 Non-Admitted Services Classification (Tier 2) for NEP26?

Feedback:

Tier 2 refinements

Some stakeholders, including NSW, Qld, SA, ACT, HGSA, the Australian Physiotherapy Association, Exercise and Sports Science Australia and CHA proposed a range of new or revised Tier 2 classes to better align with clinical practice, workforce roles, and service complexity. These included:

- creation of a dedicated Tier 2 class for accredited exercise physiologists, which are currently classified under physiotherapy, resulting in underreporting and funding misalignment
- tiered funding for outpatient pharmacy services, noting that 40.04 *Clinical pharmacy* does not differentiate between levels of care provided
- inclusion of clinical genetics services within Tier 2
- clearer delineation of classes to better identify and account for patient complexity by recognising multidisciplinary care intensity, such as differentiating 20.01 *Transplants* by transplant type to capture varying resource needs
- updates to reflect the higher complexity, autonomy, and cost of advanced practice roles, such as in physiotherapy
- introduction of new classes for advanced care planning.

Stakeholders highlighted the need for classification and funding structures that support innovative or multidisciplinary models of care, recommending:

- greater flexibility in classification to accommodate technological innovations, such as capsule endoscopy
- better support for nurse-led models, such as models in which patients are first seen by an experienced nurse
- ongoing refinement of Tier 2 to ensure information and communication technology delivered care is accurately captured and aligned with modern, patient centred models
- consultations with structural heart nurse specialists to develop guidance on 40.42 *Circulatory* funding to support education and nurse-led cardiac clinics
- inclusion of shared care, where primary and specialist providers jointly manage patient care in community settings as a formal component of the National Health Reform Agreement (NHRA), recognising its role in reducing hospital demand and improving continuity of care.

Stakeholders proposed adjustments and pricing measures to better reflect the complexity and context of care delivery. NT suggested introducing a service delivery setting variable that accounts for remoteness. Northern Health recommended weighted classifications for high-risk group vaccinations and outpatient procedures requiring extended sedation. Vic advocated for improved capture of multidisciplinary care involving more than 3 simultaneous providers. WA recommended considering transitioning 10.19 *Ventilation - home delivered* to activity based funding (ABF) based on activity and cost data.

Tier 2 definitions and supporting documentation

Stakeholders, including Qld, SA, WA, NT, ACT and Torres and Cape Hospital and Health Service proposed a range of refinements to improve clarity, consistency, and flexibility within the Tier 2 structure and definitions. Specific suggestions included:

- better align classification with actual reporting practices (particularly for multiple service provision on the same day and non-admitted services provided to admitted patients), address inconsistencies in counting rules, and improve data systems to support new models
- clearer definitions of what constitutes clinical care, with examples, and inclusion of Aboriginal and Torres Strait Islander Health Workers in the 40 series
- clarification of boundaries between non-admitted care and primary care
- updates to mental health definitions to distinguish Tier 2 clinics from community mental health services
- a formal impact assessment of proposed 2026–27 changes to the Tier 2 Definitions Manual and Compendium.

IHACPA's response

Tier 2 refinements

IHACPA considered introducing a new Tier 2 class for exercise physiology and advanced practice physiotherapy as part of the NEP Determination 2023–24 (NEP23). However, these proposals were not progressed due to feedback from states and territories and the preference to group activity by patient and clinical factors rather than provider type. For NEP23, IHACPA priced non-admitted services using Tier 2 Version 8.0 and introduced class 40.66 *Genetic counselling* to better reflect reported activity and support future cost data collection. As data from 2023–24 will inform NEP26, actual activity and cost data will be used for pricing refinement.

IHACPA reviewed the potential for a new class to capture the breadth of pharmacist services but did not propose changes for 2025–26, again due to the classification's focus on patient and clinical factors.

Tier 2 currently supports telephone and videoconference modalities, which are priced at the same level as in-person modalities. In 2025–26, IHACPA will continue engaging with jurisdictions and advisory committees to respond to recommendations from the Virtual Care Project – Final Report.

Future improvements to capturing patient complexity, multidisciplinary care, and advanced practice roles will be considered through the development of a new non-admitted classification under ANAPP. IHACPA will continue to assess proposed refinements for future Tier 2 versions, where the services are in scope for NHRA funding, in consultation with advisory groups and the Non-Admitted Care Advisory Working Group. This includes updates to the Tier 2 Definitions Manual, including clearer definitions of clinical care, recognition of advanced practice roles, and the potential inclusion of Aboriginal and Torres Strait Islander Health Workers within the 40 series.

Tier 2 definitions and supporting documentation

IHACPA acknowledges the proposed refinements to improve clarity and flexibility within the Tier 2 structure. Work to enhance definitions, metadata, and data collections is underway as part of IHACPA's 2026–27 Data Development Work Program. Specific efforts related to virtual care will continue through IHACPA's participation in the Australian Institute of Health and Welfare Virtual Care Working Group.

IHACPA will continue to collaborate with jurisdictions through its Non-Admitted Care Advisory Working Group to support the consistent application of non-admitted counting rules.

Question 4.

What considerations should inform the potential introduction and pricing of a Tier 2 class for hospital-based non-admitted voluntary assisted dying (VAD) services?

Feedback

Stakeholders provided general support for the introduction and pricing of Tier 2 classes for VAD services. NSW, Vic, CHA, QNMU, Advanced Pharmacy Australia (AdPha), and HGSA emphasised that VAD is distinct from palliative care and requires its own classification due to its specialised, multidisciplinary, and resource-intensive nature. They noted the need to reflect contributions from a broad range of professionals, including nursing, allied health, interpreters, and specialties like clinical genetics.

Stakeholders raised concerns about the legal sensitivities surrounding VAD and the need for national applicability. WA and CHA suggested a broader 'end-of-life care' class to avoid explicitly identifying VAD. NSW, Vic, SA, WA and CHA recommended that IHACPA work with states and territories to account for legislation, funding arrangements and models of care. Vic also requested guidance on concurrent funding where VAD overlaps with other services. Additionally, NSW, Vic, Qld, SA, and WA emphasised the sensitivity of VAD-related data and called for strong privacy protections aligned with relevant laws. WA noted the existence of legal penalties for data misuse and advised against explicitly identifying VAD episodes.

NT, ACT, AdPha, and Rural Doctors Association of Australia raised concerns about the high costs and logistical challenges of delivering VAD in rural and remote areas, including clinician travel, accommodation, interpreters, cultural needs, and the importance of dying 'on Country' for First Nations communities.

NSW, Vic and CHA recommended shadow pricing and pilot testing to ensure system readiness and pricing stability, with CHA suggesting pilots in both participating and non-participating hospitals, including private settings.

IHACPA's response

IHACPA will introduce 2 new Tier 2 classes for hospital based non-admitted VAD services for NEP26, which will result in the development of Tier 2 Version 10.0. The 2 new classes are:

- 20.59 *Voluntary assisted dying* (for service events in clinics led by a medical practitioner and/or nurse practitioner)
- 40.69 *Voluntary assisted dying* (for service events in clinics led by an allied health and/or clinical nurse specialist and/or clinical pharmacist).

IHACPA will use Tier 2 Version 10.0 to price non-admitted services for NEP26 to ensure this activity is appropriately captured. IHACPA has consulted with its advisory committees on the pricing of these classes, noting that Tier 2 classes cannot be shadow priced.

3.5 Mental health care

3.5.1 Refinements to the Australian Mental Health Care Classification (AMHCC)

IHACPA did not ask any specific consultation questions on the mental health care classifications but received feedback from a number of stakeholders on this area.

Several stakeholders including NSW, Vic, Qld, WA and the Royal Australian and New Zealand College of Psychiatrists (RANZCP) supported the continued refinement of the AMHCC and highlighted key areas for future development including:

- reviewing the use of the Life Skills Profile (LSP) to ensure its clinical acceptability and feasibility
- consultation with the mental health sector and workforce to incorporate perspectives of consumers with lived experience
- reviewing forensic mental health services
- accounting for defined catchments in mental health service costing, recognising that unlike physical health services, mental health care often operates within fixed geographical boundaries
- the need to improve data quality and classification accuracy, particularly around Health of the Nation Outcome Scales, LSP-16, Mental Health Phase of Care, and mental health legal status.

Other areas raised for consideration in relation to mental health pricing included:

- accounting for cost variations associated with multidisciplinary team involvement and the duration of service contacts
- specific pricing for both inpatient and outpatient consultation liaison mental health services
- examining patient days in psychiatric wards and quantifying per diem funding gaps by ward type, for example dementia wards
- creating an adjustment for mother baby units (MBUs) pricing to accommodate the additional cost burden of caring for an infant
- adjusting the weight of ‘consumer not present’ service contacts or considering a child and adolescent mental health services specific adjustment to reflect the common care model
- pricing and weighting adjustments to better reflect complexity, especially for children and adolescents and high-complexity cases
- determining pricing differences between high and low dependency units based on consultant review frequency and care intensity.

IHACPA’s response

IHACPA remains committed to refining the classification in line with the Governance Framework for the Development of the AMHCC, aiming to develop a consumer-focused, service-agnostic mental health care classification. Consultation continues through the Mental Health Working Group, which includes consumers, carers, clinicians, and health managers. Priority areas identified for AMHCC Version 2.0 refinement include the investigation into inclusion of age and principal diagnosis within the complexity model, same-day interventions, and expanding mental health legal status.

IHACPA is also working to capture mental health legal status across both admitted and community settings. Forensic services will be reviewed as data allows, with a pricing adjustment being considered for NEP26. The AMHCC is designed to reflect care from the consumer’s perspective, not service-based characteristics like ward or unit, and there are no current plans to refine service settings beyond admitted and community branches.

In 2024, IHACPA developed a tiered mental health intensive care unit (ICU) definition, including high dependency units, to support consistent reporting. This will be implemented in the ABF Mental Health Care National Best Endeavours Dataset to capture indicators such as level of care and hours in a mental health ICU.

To support accurate identification of MBUs, RANZCP has proposed a national definition. IHACPA will analyse cost and activity differentials where states and territories meet this definition, noting current variation in MBU data reporting. Data collection will continue to assess cost and clinical profiles of MBU consumers compared to other admitted mental health patients.

Service contacts without the consumer present should be reported according to business rules. The existing community mental health care data items do not allow for the identification of family or carer attendance instead of the consumer. However, as the AMHCC Version 1.1 is an age-based classification, the increased proportion of these types of service contacts will be reflected in phase costs and service contact price weights for child and adolescent services.

IHACPA notes that consultation-liaison services delivered as part of an admitted episode of care are not eligible for additional funding, however consultation-liaison services delivered by a community mental health service, including on an in-reach basis to admitted patients, may be reported providing they meet the definition of a service contact and mental health care type.

IHACPA notes that all costs, including those associated with multidisciplinary teams, longer care duration and consumer complexity, are incorporated in classification development and pricing models. These will continue to be refined over time in line with updated activity and cost data to ensure continuous improvement in mental health care pricing.

3.6 Teaching and training

IHACPA did not ask any specific consultation questions on the teaching and training classification but received feedback from a couple of stakeholders on this area.

Feedback received

NSW and Vic supported IHACPA's continued block funding in the interim whilst developing a longer-term work plan to improve the understanding of these costs across the health system.

Australian College of Rural and Remote Medicine supported block funding for rural training and called for models that enable cross-disciplinary learning, local responsiveness, and formal recognition of rural generalists as specialists under national law.

IHACPA's response

IHACPA acknowledges continued stakeholder support for maintaining block funding for teaching and training while a longer-term work plan is developed.

Transitioning to activity based or alternative funding models will require detailed analysis and consultation, including consideration of provisions under the next addendum to the NHRA. In the meantime, IHACPA expects teaching, training, and research services to remain block funded and will continue working with jurisdictions to better understand the composition of current block funding and emerging needs.

IHACPA notes that providing formal recognition of rural generalists as specialists under national law is beyond IHACPA's remit under the NHRA.

4

Setting the national efficient price

4. Setting the national efficient price

4.1 Impact of COVID-19

Question 5.

Are there any barriers to removing the remaining temporary measures introduced to manage the impact of coronavirus disease 2019 (COVID-19) for the National Efficient Price Determination 2026–27 (NEP26)?

Feedback received

Queensland (Qld), the Northern Territory (NT), Human Genetics Society of Australasia (HGSA) and Catholic Health Australia (CHA) supported removing the remaining temporary COVID-19 measures for NEP26. However, New South Wales (NSW), Victoria (Vic), South Australia (SA), Western Australia (WA), Advanced Pharmacy Australia (AdPha), CHA, and Queensland Nurses and Midwives' Union (QNMU) identified several barriers, including:

- higher costs of COVID-19 admissions compared to other viral pneumonia cases
- variation in how COVID-19 care is integrated across states and territories and hospitals
- ongoing evolution of the virus and potential need for surge capacity
- continued impact on selected Australian Refined Diagnosis Related Groups (AR-DRGs)
- risk of funding model volatility
- loss of Commonwealth funding for certain COVID-19 antivirals.

To address these, stakeholders including NSW, Vic, Qld, SA, WA, the Australian Capital Territory (ACT), CHA, AdPha, and QNMU recommended:

- reviewing the effectiveness of temporary measures
- reviewing how activity based funding (ABF) accounts for high-cost, non-Pharmaceutical Benefits Scheme (PBS) COVID-19 treatments
- assessing the impact of future waves before removing measures
- using 2023–24 data and consulting with states and territories on impacts
- maintaining adjustments until COVID-19 cost profiles align with other patients
- considering a price stabilisation and transition approach
- modelling and monitoring post-removal impact to ensure pricing stability.

IHACPA's response:

The Independent Health and Aged Care Pricing Authority (IHACPA) acknowledges stakeholder support for removing COVID-19 pricing arrangements for NEP26, as well as concerns about ongoing impacts and potential pricing volatility. These factors have been considered in shaping the approach to phase out the remaining temporary measures. IHACPA intends to remove the remaining temporary COVID-19 measures for NEP26.

IHACPA engaged with its clinical and technical advisory committees to review the exemption from the safety and quality adjustments for COVID-19 patients and the removal of the COVID-19 treatment adjustments for specific AR-DRGs. The extension of the intensive care unit (ICU) adjustment beyond the specified list of hospitals was also reviewed.

Based on analysis and consultation with stakeholders, IHACPA intends to remove the COVID-19 treatment and temporary ICU pricing adjustments and restore the adjustments for hospital acquired complications (HACs) and avoidable hospital readmissions (AHRs) for patients with COVID-19. These measures are no longer required to account for the impact of COVID-19 on service delivery. Variations in episodes associated with COVID-19 patients will be addressed through more sustainable and appropriate measures, including through AR-DRG Version 12.0, which accounts for symptomatic COVID-19 in its complexity model. IHACPA also intends to incorporate COVID-19 as a risk factor in statistically relevant HACs and AHRs risk adjustment categories for NEP26.

4.2 Adjustments to the national efficient price

4.2.1 Intensive Care Unit adjustment

Question 6.

In cases where AR-DRG price weights account for ICU cost variations, should ICU costs be bundled?

Feedback received

ICU cost bundling

NSW, Vic, Qld, SA, WA, NT, QNMU, Rural Doctors Association of Australia (RDAA) and CHA expressed strong opposition to bundling ICU costs, citing risks to transparency, equity, and clinical decision-making. They expressed concern that bundling could mask cost variations, particularly in referral hospitals managing complex patients, and disadvantage rural hospitals and high dependency units (HDUs) not formally designated as ICUs.

Stakeholders argued that the AR-DRGs lack the sensitivity to reflect ICU cost differences, and bundling may obscure variations in resource use and care models. SA highlighted funding inefficiencies in neonatal care, noting that current definitions can result in misaligned funding when newborns under 9 days old are transferred from maternity wards to paediatric ICUs. This discrepancy was seen as inconsistent with clinical best practice and may not accurately reflect the care provided, leading to inefficiencies in resource allocation. Overall, they rejected the assumption that bundling would improve care flexibility, stressing that ICU use is driven by clinical need, not funding structures.

ACT was the only stakeholder open to bundling, provided it did not increase financial risk for hospitals.

Vic, NSW, SA and WA recommended a review of current price bundling for Major Diagnostic Category (MDC) 15 *Newborns and Other Neonates* (MDC15) to improve ICU and newborn pricing structures.

General comments

Various stakeholders such as NSW, Vic, SA and WA made the following recommendations to improve ICU and newborn pricing structures:

- remove the specified list of ICUs and the current volume-based eligibility thresholds and have a broadly applicable ICU adjustment
- improve ICU data quality and specificity in the short-term to support future changes to the ICU pricing model
- explore approaches for hospitals that use ICU only in high-risk or fallback scenarios.

IHACPA's response

ICU bundling

IHACPA acknowledges that there are major concerns around the negative impact of bundling on the consistency and fairness of funding for ICUs. IHACPA notes that bundling would only be considered where appropriate, such as in AR-DRGs where ICU use is highly predictable. IHACPA emphasises that bundling ICU costs would benefit rural and regional hospitals or HDUs not formally designated as ICUs as the bundled AR-DRG price would be higher than the unbundled price. However, IHACPA does not intend to bundle ICU costs for NEP26.

General comments

IHACPA continues to review the ICU adjustment to the national efficient price (NEP). The outcomes of the review to date indicate that existing data collections do not support substantial changes to the existing ICU adjustment methodology.

IHACPA will progress updates to activity data specifications to improve the quality and coverage of ICU data collection and work with jurisdictions to improve the consistency of costing practices. These refinements and expanded ICU data collection will inform the ongoing review and implementation of broader changes in future years, if required.

The ICU adjustment review is also considering the specified list of ICUs, current volume-based eligibility thresholds, and price bundling for MDC15. Questions raised during the development of the Pricing Framework for Australian Public Hospital Services 2025–26, along with all stakeholder feedback received through advisory committees, are being considered as the review progresses. The outcomes of the ICU review are expected to inform determinations beyond 2026–27.

4.2.2 Review of pricing models and adjustments

The Mid-Term Review of the National Health Reform Agreement (NHRA) Addendum 2020–2025 recommended a reduction in calculation complexity for the pricing adjustments and a review of the Indigenous and rural and remote pricing adjustments. Additionally, it recommended that IHACPA explore a separate and further adjustment for smaller states and territories to compensate for the lower scale and volume and higher disproportionate costs associated with these populations. To inform IHACPA's review, the consultation paper also asked stakeholders about evidence to suggest that the actual costs of care are not being accurately reflected in cost data collections and how IHACPA can support states and territories in reporting these. Stakeholder feedback provided through this year, and previous pricing framework consultations will be considered as part of IHACPA's review.

Question 7.

In addition to reviewing the interactions underpinning the calculation of the Indigenous adjustment, are there other technical refinements to the existing pricing models that could support high-quality, culturally appropriate care for First Nations peoples?

Feedback received

Indigenous adjustment

Stakeholders including the Australian College of Rural and Remote Medicine, NSW, Vic, Qld, WA, NT, ACT, Torres and Cape Hospital and Health Service (THHS), CHA, Australian Multicultural Action Network Inc (AMAN) and QNMU recommended reviewing the current methodology and its interaction with remoteness adjustments to better reflect actual costs, health needs, and social health factors. They emphasised the importance of recognising the unavoidable costs associated with delivering culturally safe care, such as patient transport from remote communities, which is often necessary to access appropriate services and support continuity of care.

Several stakeholders, including NSW and Qld, supported the use of pricing levers to incentivise culturally appropriate, evidence-based models of care. Vic and NT recommended reviewing geographic weightings, with Vic proposing a cost recovery model aligned with variations between states and territories. NT also suggested a diagnosis-specific adjustment based on care type, severity, and complexity.

NSW recommended reviewing the terminology used for remoteness adjustments, with consultation from First Nations peoples to ensure cultural appropriateness. Other stakeholders proposed splitting the Indigenous adjustment into clinical and geographic components and funding culturally tailored outreach initiatives such as case conferences.

Additionally, NSW, NT, ACT, QNMU, THHS and CHA recommended embedding culturally safe roles and associated training costs into ABF pricing and related adjustments. NT further called for designated funding to support patient relocation from remote communities, highlighting the link between transport and equitable access to culturally safe care. AdPha recommended technical refinements to pricing models to support equitable access to medicines for First Nations peoples, particularly during transitions of care and on discharge.

Stakeholders including NSW, Qld, NT and CHA highlighted the need for improved data processes to better capture the true costs of episodes of care and to strengthen data sovereignty. SA, WA, NT and THHS recommended integrating public health and primary health care systems to more effectively support First Nations people and their communities.

IHACPA's response

For NEP26, IHACPA will retain the existing methodology for calculating the Indigenous adjustment while it undertakes a multi-year review into the costs and pricing of care delivery to First Nations peoples. The review will focus on the interactions between various cost drivers and individual characteristics of the population (Indigenous identification, health status, social-cultural, and geographic health factors). The review will use research and consultation to understand the key drivers of health inequities including potential indicators of poor quality care. It will seek to understand the indicators of these drivers in available data sets and their relevance to the Indigenous adjustment, as well as scope areas for future work, and will be conducted in close consultation with First Nations peoples.

Question 8.

What principles and processes could guide model simplification in relation to IHACPA's adjustments and pricing models?

Feedback received

Principles

WA, NT, ACT, CHA, AdPha, and QNMU recommended transparency, noting that simplified models should be understandable and demonstrate clear links to decision making and be periodically reviewed.

Stakeholders including AdPha, NSW, WA, HGSA and CHA noted the importance of equity, noting that states and territories must continue to demonstrate legitimate cost variations, particularly for rural and remote services and smaller states and territories. Regular impact assessments should be undertaken to ensure the pricing model continues to reflect cost, support access, and promote efficiency.

Several stakeholders suggested materiality thresholds could be used to retain adjustments that account for significant cost variations and remove unnecessary adjustments that do not alter price weights.

NSW, SA and CHA supported evidence-based simplification based on robust data sets and reflecting current clinical care practices.

Some stakeholders including WA, SA, CHA and QNMU suggested models must be adaptable to account for future changes in healthcare delivery.

WA, NT and CHA further highlighted the importance of ensuring national applicability within the legislated context but that states and territories that cannot achieve economies of scale should not be impacted by simplification.

Processes

Various stakeholders recommended the following processes to guide model simplification in relation to IHACPA's adjustments and pricing models:

- ongoing consultations on the technical and practical impacts of model simplification and a phased implementation to model simplification with clear transition planning
- adjustment mapping against policy objectives to identify impact and areas of consolidation including combining of adjustments considering economies of scale
- scenario testing and modelling.

IHACPA's response

Most of the principles outlined in stakeholder feedback closely align with IHACPA's current Pricing Guidelines and IHACPA's Assessment of Adjustments to the National Pricing Model Policy. IHACPA will incorporate this feedback in its upcoming review.

Question 9.

After accounting for current pricing model adjustments and block funding arrangements, what are some drivers of unmet cost variation in public hospital service delivery for people residing in rural and remote areas of Australia?

Feedback received

Workforce, infrastructure and service delivery challenges

Stakeholders reported that workforce shortages remain a significant issue in rural and remote hospital service delivery. QNMU, National Rural Health Alliance (NRHA), NSW, WA, SA, NT, CHA, RDAA, AdPha, and AMAN highlighted the ongoing difficulty in recruiting and retaining skilled staff. This challenge has led to a heavy reliance on locum and agency workers, which significantly increases labour costs. These costs are further compounded by the need to offer incentives such as housing, relocation support, and additional allowances to attract and retain staff in remote areas.

Digital infrastructure limitations were also identified as a key driver of cost variation. AMAN, AdPha, CHA, NRHA, NSW and WA noted that poor connectivity in remote regions hampers the implementation of telehealth services and electronic medical records. As a result, the cost of delivering digital health services is higher, and many facilities face increased capital and maintenance costs due to outdated infrastructure and logistical challenges.

Several stakeholders, including SA, WA, QNMU, CHA and NRHA, observed that small rural hospitals are often required to maintain a broad range of services, such as emergency and maternity care, despite experiencing low and unpredictable patient activity. This results in high fixed costs per episode of care, which are not adequately addressed by current funding models. Additionally, the Leukaemia Foundation and WA raised concerns about fragmented governance structures, particularly in specialised areas like cancer treatment, which contribute to inefficiencies and gaps in access to care.

Geographic, socioeconomic and systemic cost drivers

Travel, transport and accommodation costs were widely cited as major cost drivers in rural and remote healthcare delivery. Stakeholders noted that both patients and clinicians often need to travel long distances, sometimes by air, to access or provide care. These costs are substantial and frequently excluded from existing funding models, despite being essential to service delivery in remote areas. The burden is especially pronounced for rural populations, especially First Nations communities and for patients requiring complex treatments, such as those for blood cancers.

NT, NRHA, CHA, the Leukaemia Foundation, and RDAA highlighted socioeconomic and health disparities as key unmet drivers of cost. Rural populations, particularly First Nations communities, experience higher rates of chronic disease, disability, and poorer health outcomes. These disparities increase the complexity and cost of care, placing additional strain on already limited resources.

Stakeholders including SA, WA, QNMU, CHA and NRHA described systemic service gaps that exacerbate cost pressures. Shortages in primary healthcare services and aged care services, and the lack of step-down facilities mean that rural hospitals often serve as the default provider for a wide range of health and social needs. This results in longer hospital stays and more complex patient presentations, particularly for those with chronic conditions.

NT and RDAA raised concerns about the limitations of the current remoteness classification system Australian Statistical Geography Standard Remoteness Area and argued it does not accurately reflect the true isolation of some communities. In some cases, rural services are incorrectly mapped to urban centres, leading to distorted data and misallocated resources.

NSW, Qld, NT, ACT, NRHA and RDAA highlighted how natural disasters and climate-related events disproportionately affect rural hospitals, increasing costs and disrupting service delivery. Rural hospitals also face underfunding for training and education, limiting their ability to support workforce development and supervision.

IHACPA's response

IHACPA acknowledges the significant and persistent challenges faced by rural and remote health services, as highlighted in stakeholder feedback. IHACPA remains committed to ensuring that pricing and funding models reflect the unique circumstances of these communities. For NEP26, IHACPA will maintain the current methodology for determining the rural and remote adjustments. The treatment location adjustment aims to address any cost variations that are systemic at a hospital level. IHACPA will incorporate stakeholder feedback in its ongoing work program of refining the rural and remote patient adjustment.

For future pricing determinations, the rural and remote patient adjustment component of the review will address the concerns raised by stakeholders around drivers of unmet cost variation. This review will focus on the cost drivers specifically relevant to regional and remote settings, including workforce and supply costs. The review will also consider the impacts of geographical distance and isolation on patient and provider travel and patient discharge patterns. By determining the extent to which these drivers are evident in available data sets, IHACPA can work towards better capturing this variation in its pricing models.

Question 10.

After accounting for current pricing model adjustments and block funding arrangements, what are some cost drivers that impact the ability of hospitals and local hospital networks (LHNs) to achieve economies of scale under the ABF model?

Feedback received

Stakeholders identified various cost drivers that limit the ability of hospitals and LHNs to achieve economies of scale under the ABF model.

Stakeholders including NSW, SA, WA, NT, ACT, CHA, QNMU and NRHA referenced structural and service delivery constraints such as:

- smaller hospitals are required to maintain essential services (e.g. emergency, maternity, mental health, diagnostics) around the clock, regardless of patient volume, resulting in high fixed costs
- workforce flexibility is constrained by industrial agreements and accreditation standards
- geographic dispersion and decentralised service delivery lead to duplication of systems and services, increasing per-unit costs
- hospitals absorb costs due to gaps in aged care, disability, and primary care, leading to longer patient stays and reduced efficiency.

High cost, low-volume services and infrastructure limitations were highlighted by NSW, Qld, WA, NT, ACT, CHA, QNMU, NRHA and AdPha:

- specialised services (e.g. oncology, organ transplants, paediatrics, genomics) involve high infrastructure and labour costs but serve small patient cohorts
- personalised medicine and rare disease care require individualised assessments and highly trained professionals, limiting scalability
- smaller and rural hospitals face elevated costs for utilities, equipment and facility maintenance
- compliance with updated standards (e.g. sterile compounding) increases operational costs
- limited digital infrastructure and investment capacity hinder process optimisation and data sharing
- lower acute patient volumes in co-located multi-purpose services may be distorting reported acute care costs in regional and remote areas, as fractional costing—allocating shared costs across services—can understate the true cost of acute care delivery.

NSW, Qld, NT, ACT, NRHA and RDAA raised funding misalignment and external pressures including:

- national pricing benchmarks may not adequately reflect local cost variations (e.g. wages, freight, contractor premiums), leading to funding mismatches.

IHACPA's response

IHACPA notes the multiple cost drivers outlined by stakeholders that are not currently being addressed in the NEP pricing model. IHACPA will incorporate stakeholder feedback in its ongoing work program of refining and developing pricing models including where relevant, as part of the block funding review.

As part of its review of the NEP and national efficient cost (NEC) price weights, IHACPA will review services delivered in smaller states and territories. This component of the review will focus on issues distinct from those considered in the first 2 components. A central focus will be variation in pricing model performance across hospitals of different sizes and population needs to examine issues around economies of scale and scope. The review will also investigate common drivers of legitimate and unavoidable cost variations in smaller states and territories, and whether these can be accounted for through nationally applicable adjustments consistent with the requirements of the *National Health Reform Act 2011* and NHRA.

Question 11.

What, if any, evidence is there to suggest that the actual costs of care are not being accurately reflected in cost data collections and how can IHACPA support jurisdictions in reporting these?

Feedback received

Costs of care not reflected in cost data collections

Stakeholders including the HGSA, AdPha, the Australian Dental Association (ADA), CHA, Qld, SA and NT highlighted that key components of care—such as pathology, pharmacy, virtual care, and post-procedure monitoring—may be misallocated to the incorrect patients. There were concerns that these errors in allocation could lead to the under-pricing of related services. Qld, for example, described how hub-and-spoke service models—where patient care is shared between ABF and non-ABF facilities—can lead to misaligned cost attribution. SA noted that patient transport costs in rural areas are often underrepresented in national models.

Additionally, time lags in data collection and inconsistencies in reporting—such as variations in how institutions apply IHACPA's costing guidelines, including the use of relative value units or discretionary allocation methods—can compromise the accuracy and comparability of cost data across settings.

Several stakeholders, including ADA, AdPha, QNMU and Qld, raised concerns that current coding frameworks do not adequately capture clinical complexity or reflect evolving scopes of practice, which may impact cost allocation practices. QNMU specifically recommended research into coding accuracy and human error to better understand the actual cost of care. ACT also suggested further investigation into the costs associated with community-based care, particularly where mental health complexity intersects with co-occurring conditions such as homelessness—areas that are not well defined in current datasets.

Barriers to accurate costing

Stakeholders from Qld, WA, QNMU, and CHA expressed concern about critical workforce and infrastructure shortages that affect the quality of clinical costing and coded data, particularly in smaller hospitals. These facilities often lack sufficient clinical costing, coding, and administrative staff, which undermines the accuracy and completeness of data. Information and communications technology (ICT) limitations further hinder the ability to attribute costs precisely. Qld highlighted that the clinical costing and coding workforce is aging and under-resourced, with no formal training pathways or succession planning in place. WA echoed these concerns, pointing to persistent staffing shortages and inadequate ICT infrastructure in smaller facilities.

State and territory and facility-level variation was another key theme raised by stakeholders. To address these challenges, stakeholders including AdPha, Qld, WA, ACT, ADA, and CHA recommended that IHACPA refine its Tier 2 Non-Admitted Services Classification and improve coding training. WA suggested tailored training, ICT tool development, and more flexible data quality expectations for small facilities. ACT proposed elevating the teaching, training, and research dataset to a national minimum dataset, while Qld called for national leadership in workforce development for clinical costing and coding professionals, advocating for a coordinated national strategy to strengthen coding and costing capability across states and territories.

IHACPA's response

IHACPA notes stakeholder feedback around potential limitations in the current cost data collection process. IHACPA will continue to work with its advisory committees to explore opportunities for further improvement in cost collections. This will ensure that all costs are appropriately accounted for in pricing models. While IHACPA produces resources to support states and territories in local training requirements, workforce development and training is ultimately the responsibility of states and territories as system managers.

IHACPA will also consider the issues raised by stakeholders in its multi-year review of the NEP and NEC price weights.

4.3 Supporting the pricing of community mental health care

Question 12.

What, if any, further measures are required in NEP26 to support the second year of community mental health care services transitioning to ABF?

Feedback received

Stakeholders suggested the following measures to support the second year of transitioning community mental health care services to ABF under NEP26:

- maintain or expand block funding arrangements for specialised or low-volume services that are not financially sustainable under ABF, to ensure continuity of care and equitable access
- continue the composite ABF and block funding model in 2026–27 to support funding stability
- undertake a national review of activity data quality and consistency across states and territories to assess readiness for further transition and to avoid premature implementation
- consider systemic challenges in applying ABF to mental health services, including risks of underfunding, workforce shortages, increasing complexity of patient presentations, and care episodes involving children or adolescents without the client present
- provide targeted support for regional, remote, and culturally diverse services, with a focus on the needs of culturally and linguistically diverse youth and First Nations communities
- introduce transitional safeguards and monitoring mechanisms, such as floor payments, volume caps, and risk-adjusted loadings, co-designed with stakeholders to monitor service impact and support equitable outcomes.

IHACPA's response

IHACPA will continue to use the Australian Mental Health Care Classification (AMHCC) Version 1.1 for pricing admitted and community mental health care under NEP26.

IHACPA has reviewed the transitional block funding measures that were introduced in the NEC Determination 2026–27 (NEC26) to support the transition of community mental health care to ABF. While several stakeholders recommended retaining the transitional block funding criteria for specialised forensic and low volume LHNs in 2026–27, there were limited calls to extend the composite model.

Following further analysis, IHACPA does not intend to extend the composite ABF and block funding model for community mental health care services for NEC26, which is consistent with its intended one-year application. However, IHACPA will maintain the transitional block funding criteria for NEC26, meaning specialised forensic establishments and LHNs that continue to meet the criteria will be block funded for NEC26. The criteria for both will be reviewed for the NEC Determination 2027–28.

4.4 Harmonising price weights across settings

Question 13.

What, if any, clinical reasons are there for patients requiring chemotherapy, dialysis, interventional imaging or gastrointestinal endoscopy to be treated in an admitted versus non-admitted setting, and how could this be accounted for in a price harmonisation methodology?

Feedback received

Stakeholders including NSW, Qld, WA, NT CHA, and RDAA advised that patients with complex conditions, comorbidities, or requiring intensive monitoring often need to be treated in an admitted setting to ensure safety and appropriate care. WA highlighted that paediatric patients undergoing chemotherapy require specialised inpatient care due to unique physiological responses and treatment risks. SA explained that they allow endoscopy to be provided in an admitted rather than non-admitted setting where there is the administration of general anaesthesia required for clinical reasons.

CHA stressed that interventional imaging procedures performed in admitted settings are often linked to higher-risk cases where patients need sedation, anaesthesia, or complex intervention. They also asserted that gastrointestinal endoscopy in admitted patients is generally reserved for those needing therapeutic interventions, complex polypectomy, or with comorbidities requiring anaesthesia and post-procedure observation.

WA, NT, QNMU and RDAA noted that patients from rural or remote areas may require admission due to travel distances, limited local outpatient services, or the inability to safely return home post-procedure. NT added that hybrid models combining telehealth and face-to-face care are essential in remote areas and should be funded appropriately given their high infrastructure and operational costs.

AdPha, Vic, and Qld raised concerns that some admissions occur not for clinical reasons but due to funding rules, logistical constraints, or limitations in PBS coverage for treatments like chemotherapy. QNMU, Vic, NT and CHA cautioned that price harmonisation must not incentivise care based solely on cost but instead support equitable access and reflect patient-specific needs, including cultural safety and social health factors.

Vic, SA and CHA recommended that harmonisation be guided by clinical best practice rather than administrative assumptions and emphasised the importance of comparative analysis and clinician consultation to ensure care equivalence. Other stakeholders warned that aligning admitted care price weights with non-admitted settings without accounting for service complexity may compromise care quality and increase reporting inconsistencies. Therefore, it was recommended to incorporate risk stratification and complexity adjustments to protect high-need patients and specialised services.

IHACPA's response

IHACPA acknowledges stakeholder feedback on the systemic and clinical factors influencing the delivery of chemotherapy, dialysis, interventional imaging, and gastrointestinal endoscopy in admitted versus non-admitted settings.

However, the responses to the consultation paper indicated that certain states and territories record mostly admitted episodes of care for certain services, such as dialysis, while other states and territories record mostly non-admitted episodes for the same service. This suggests that the differences reflect administrative decisions rather than clinical differences.

IHACPA will seek to develop a harmonisation methodology that:

- incentivises lower-cost modalities where clinically appropriate
- maintains standards of care
- reflects representative price weights across modalities
- accounts for factors contributing to cost and price variance such as patient and treatment complexity.

Despite the extensive work already conducted, IHACPA acknowledges further work and consultation are required for any changes to be made to the harmonisation methodology. For NEP26, the existing harmonisation approach for Tier 2 Non-Admitted Services Classification classes 10.02 *Interventional imaging* and 10.06 *Endoscopy – gastrointestinal* will remain unchanged. IHACPA will also not proceed with harmonisation of dialysis or chemotherapy services for NEP26. IHACPA notes that issues related to the data associated with harmonisation of chemotherapy remain and will require further consultation with stakeholders.

4.5 Other pricing related refinements

Pricing for the private healthcare system

Feedback received

The Australian Society of Plastic Surgeons and QNMU proposed a national pricing system for private healthcare, modelled after the NEP, to standardise funding and improve transparency. QNMU noted that the financial instability of private hospitals could increase pressure on the public system, emphasising the need for funding models that reflect actual care costs and structural realities.

IHACPA's response

IHACPA acknowledges stakeholder interest in a national pricing system for private healthcare, however notes this program of work is not within IHACPA's remit.

Pricing for patients with disabilities

Feedback received

NSW and the Royal Australian and New Zealand College of Psychiatrists recommended applying a pricing adjustment for patients with disability, citing the additional complexity, time and resources needed for their care are not currently captured in the price weights. For example, NSW proposed sustainable funding for multidisciplinary clinics serving patients with complex disabilities, which reduce admissions and improve care efficiency.

IHACPA's response

IHACPA does not currently collect sufficient data on level of disability. The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) captures limited data related to disability and has no means to capture data on different functioning levels. However, existing mechanisms in the pricing model may overlap and account for some of the issues identified, including higher price weights for more complex episodes and adjustments for longer lengths of stay. ICD-10-AM Thirteenth Edition includes new codes to flag waiting periods related to arrangement of disability services.

In the Australian National Subacute and Non-Acute Patient Classification and AMHCC, functional measures are used to identify the increased resources associated with caring for all consumers, not just those with disability. This is in accordance with clinical guidance on how best to assess resource utilisation among these consumer groups. In emergency and non-admitted care, consumers with disability cannot generally be identified in the data collections. As such, IHACPA cannot investigate a pricing adjustment for this cohort at this stage.

5

Setting the national efficient cost

5. Setting the national efficient cost

5.1 Review of block funding criteria and arrangements

Question 14.

What policy principles and considerations should guide the Independent Health and Aged Care Pricing Authority's (IHACPA's) workplan for the review of the various existing block funding criteria and arrangements?

Feedback received

Stakeholders broadly supported principles that reflect the diverse needs of public hospital services and guide IHACPA's review of block funding arrangements.

New South Wales (NSW), Victoria (Vic), Western Australia (WA), Australian Capital Territory (ACT), Human Genetics Society of Australasia (HGSA) and the Rural Doctors Association of Australia (RDAA) emphasised the importance of equity and access as principles to guide the block funding review. These stakeholders advocated for funding models that support fair access across regions, particularly for rural and remote communities. They recommended that block funding reflect patient-specific needs, including cultural safety and social health factors. ACT also proposed that public health funding be considered within the scope of the review.

The Queensland Nurses and Midwives' Union (QNMU) and Catholic Health Australia (CHA) advocated for transparency and accountability to guide the block funding review, calling for an evidence-informed approach to revising block funding criteria. This included emphasising the importance of clearly demonstrating how data informs funding decisions. QNMU stressed that any move away from block funding must be based on evidence.

South Australia (SA), WA, CHA and QNMU supported flexibility and adaptability as principles to guide the block funding review. These stakeholders recommended funding arrangements that respond to changing healthcare needs and operational constraints, such as workforce shortages. SA proposed considering activity based funding (ABF) for block-funded sites within local hospital networks where similar services are delivered across multiple locations.

Vic, Queensland (Qld) and HGSA advocated for support for specialised services and emphasised the need to maintain block funding for high-cost, low-volume services that are not viable under ABF. HGSA provided the example of clinical genetics services, which require careful consideration and assistance from block funding methods to ensure Australians from both metropolitan and regional or rural areas receive best practice care in an equitable and timely manner.

NSW, Qld, Northern Territory (NT) and CHA noted the importance of data quality and improvement for block funding pricing decisions and stressed the importance of high-quality, multifactorial data to inform funding decisions. NSW noted that IHACPA's evidence-based approach may require refinement to reflect service variation and differences between states and territories, including consideration of volume, cost price ratio, overall facility and district case-mix, length of stay and number of separations across both metropolitan and rural or regional settings. NT recommended flexibility in evidence requirements to accommodate local contexts.

WA, RDAA, QNMU, and CHA considered stakeholder engagement in the block funding review to be essential. They supported inclusive consultation processes, including community representation, to ensure diverse perspectives are reflected in policy development.

The Australian College of Rural and Remote Medicine expressed concern about the sustainability of rural services and called for stable, flexible block funding to support small rural hospitals facing financial strain due to workforce shortages and geographic isolation. They recommended rural loadings for services such as mental health, emergency, and maternity care.

Vic stressed that the criteria for determining eligibility for block funding should ensure national consistency, with comparable hospitals across different states and territories eligible for block funding. They also requested clearer policy guidelines around scope and eligibility for block funding, particularly in relation to standalone hospitals providing forensic mental health.

IHACPA's response

IHACPA acknowledges the valuable feedback received through stakeholder consultation on the policy principles and considerations for the review of block funding arrangements. IHACPA has incorporated this feedback into the policy and analytical frameworks that will underpin the review, which will be progressed in consultation with IHACPA's advisory committees.

The development of policy principles for the block funding review builds on IHACPA's existing Pricing Guidelines to ensure alignment with its broader pricing policy. These principles are intended to be adaptable for future iterations of the pricing framework, where appropriate.

Due to ongoing analysis, IHACPA will not revise the block funding eligibility criteria for standalone hospitals for the National Efficient Cost Determination 2026–27 and will continue to review these criteria in 2026. The block funding eligibility criteria for small rural hospitals and rural and regional local hospital networks delivering a low volume of community mental health services will also be considered for future determinations.

5.2 High cost, highly specialised therapies

Question 15.

As the current arrangements for high cost, highly specialised therapies (HSTs) have been in place since 2020, what, if any, refinements are required to ensure they remain fit-for-purpose?

Feedback received

Stakeholders highlighted the need for significant refinements to ensure current funding arrangements for high cost HSTs remain fit-for-purpose.

NSW, Vic, Qld, SA, Advanced Pharmacy Australia (AdPha), the Peter MacCallum Cancer Centre (Peter Mac), Australia's Cell and Gene Catalyst (The Catalyst), Leukaemia Foundation, CHA and Gilead Sciences emphasised that current funding models are either unsustainable or incomplete. They argued that reforms are needed for better coding and data systems to support ABF and track therapy costs accurately to better reflect the full cost of therapies, including ancillary services and infrastructure. Stakeholders also highlighted the complexity of administrative processes, particularly reconciliation and cross-border payments, and described approval pathways as fragmented, urging a nationally consistent and streamlined approach. In addition, HGSA, the Leukaemia Foundation, and CHA emphasised the need for tailored funding and data infrastructure to support genomic and rare disease therapies.

ACT, CHA, and RDAA called for greater transparency and involvement of stakeholders, including clinicians, in funding decisions and transitions. Peter Mac also supported a collaborative national approach, led by IHACPA and the Health Technology and Genomics Collaboration, to develop a data-driven costing model for CAR-T therapy that incorporates empirical input from leading treatment sites.

AdPha, the Leukaemia Foundation, HGSA, CHA, and QNMU raised concerns about geographic and systemic inequities that continue to limit access to high cost HSTs. They advocated for reforms that ensure equitable access across states and territories, particularly for patients in rural and remote areas.

IHACPA's response

IHACPA recognises that while the current block funding model has enabled timely access to high cost HSTs since 2020, refinements may be necessary to ensure it remains responsive to clinical and operational realities, particularly as the use of these therapies continues to grow. IHACPA will consider undertaking a more detailed review of these arrangements, based on stakeholder feedback, to inform potential changes in future determinations.

Question 16.

What pricing considerations are pertinent for these and other high cost HSTs?

Feedback received

NSW, Qld, SA, ACT, QNMU, Leukaemia Foundation and HGSA emphasised the need for transparent, data-driven pricing models that reflect the true cost of high cost HSTs. Stakeholders supported the inclusion of all relevant costs in pricing models to ensure comprehensive coverage and avoid underfunding. They argued that this should include transport costs, regional variations, and the higher costs associated with providing specialised services in remote areas.

Vic, SA and NT recommended regular reviews involving stakeholders and updates to pricing models to keep pace with advancements in medical technology and treatment protocols.

CHA recommended that pricing clearly differentiate between upfront and ongoing costs for high cost HSTs and suggested exploring financial risk sharing approaches to pricing, where payment is aligned with the value or outcomes of care, as opposed to volume.

NSW requested that cost and activity data that is subject to the Commonwealth contribution funding cap be reported separately from cost and activity data that is outside of the Commonwealth contribution funding cap in the national efficient cost determination.

The Catalyst recommended centralised funding for treatment costs and the introduction of clearer pricing and service codes.

IHACPA's response

IHACPA recognises the importance of developing pricing models for high cost HSTs that are transparent, comprehensive, and adaptable to the evolving landscape of clinical care and service delivery. In response to stakeholder feedback, IHACPA will consider undertaking a more detailed review of these arrangements.

6

Data collection

6. Data collection

6.1 Assurance of cost data

Question 17.

Given high quality cost data is a key input to informing the national efficient price (NEP), how can the Independent Health and Aged Care Pricing Authority (IHACPA) ensure the data received through the National Hospital Cost Data Collection (NHCDC) continues to be accurate, robust and fit-for-purpose?

Feedback received

Nationally consistent approaches

New South Wales (NSW), Victoria (Vic), and Catholic Health Australia (CHA) supported enhancements to the NHCDC Dashboard to improve data access, transparency, and reconciliation. Western Australia (WA) suggested working closely with states and territories to better understand cost bucket differences.

Stakeholders including NSW, Vic, the Australian Capital Territory (ACT), CHA and Human Genetics Society of Australasia (HGSA) highlighted the importance of nationally consistent guidelines, clear templates, and timely clarification mechanisms. They also supported efforts to standardise data flows and improve alignment with hospital general ledgers.

NSW, Vic, South Australia (SA), ACT, Queensland Nurses and Midwives' Union (QNMU), CHA, and HGSA emphasised the need for robust validation processes, clear costing guidelines, and consistent data definitions. There was strong support for IHACPA's data quality initiatives, including the Data Quality Framework and Independent Financial Review (IFR), alongside calls for embedded monitoring, evaluation, and local data assurance. The Northern Territory (NT) similarly called for nationally applied checks and balances to ensure consistent data assurance across states and territories, particularly to protect smaller states and territories from disadvantage.

Stakeholders also advocated for embedded monitoring, evaluation, and locally driven data assurance, with NT further recommending that IFRs be targeted towards advancing pricing framework priorities.

Costing practitioner education and training

Costing practitioner education and training continues to be a concern of stakeholders from previous consultation reports. Queensland (Qld), WA, and NT highlighted the shortage of skilled costing practitioners and the need for ongoing training. WA and Qld highlighted the need for tailored training and workforce reviews to strengthen costing capability, particularly in smaller states and territories. NT emphasised the structural disadvantages faced by smaller states and advocated for IHACPA to play a stronger role in clinician education and technical communication.

Equity and representation in data collection

Australian Multicultural Action Network Inc (AMAN) and NT raised issues around equity in data collection and representation. AMAN recommended integrating culturally and linguistically diverse (CALD) status into patient-level costing data and establishing a multicultural advisory mechanism.

Patient product reporting improvements

A stakeholder proposed for devices to be recorded as their own line item in the NHCDC data collection with 'consumables' instead of a generic value in the 'prosthesis' or 'supplies' bucket. They further suggested that theatre time and intensive care unit (ICU) time are captured to ensure these are comparable across hospitals.

Advanced Pharmacy Australia (AdPha) highlighted a specific gap in how pharmacy services are captured in cost data. They noted that while medicine supply is typically recorded, clinical pharmacy activities may not be accurately allocated to patients. They recommended targeted costing studies and improved data collection guidance to better reflect the value of these services. CHA emphasised the need for clear articulation of roles and responsibilities across states and territories, local hospital networks, and hospitals. They also recommended mechanisms like dedicated feedback channels and IHACPA-facilitated troubleshooting.

IHACPA's response

Nationally consistent approaches

IHACPA supports the need for robust validation processes, nationally consistent costing guidelines, templates and definitions, and will continue to work with states and territories to enhance these areas to support uniformity in data collection and reporting. IHACPA will continue to improve the Data Quality Framework and NHCDC Dashboard, incorporating features that enhance data access, reconciliation, transparency and support stakeholders in undertaking improved monitoring, evaluation and data assurance in state and territory costing units.

IHACPA's Data Request Specifications (DRS) for the NHCDC aim to support nationally consistent data submissions and the Australian Hospital Patient Costing Standards (AHPCS) provide guidance for the consistent application of costing standards and practices. IHACPA regularly reviews and updates the DRS and AHPCS to align to changes in classifications or address feedback from states and territories. All states and territories are required to submit a Data Quality Statement alongside their NHCDC submission, providing comment on their application of the standards and any deviation away from expected practice.

IHACPA uses the IFR process to provide assurance of consistent application of the AHPCS and ensure the data is robust and fit-for-purpose for the development of the NEP. In 2025, IHACPA has conducted site reviews across states and territories, and a deep dive review of ICU costs will support pricing framework priorities. IHACPA will continue to enhance the IFR to ensure rigorous validation of submitted data and look to implement improvements in response to findings of the IFR where appropriate.

Costing practitioner education and training

As the system managers, states and territories hold primary responsibility for the implementation of initiatives relating to training costing practitioners. IHACPA supports these efforts by providing a range of educational resources and professional development opportunities, including through the annual IHACPA Conference. Additionally, IHACPA supports states and territories to resolve costing queries throughout the NHCDC submission process and will continue to do so in future collections. IHACPA's enquiry mailbox is dedicated to managing all external queries relating to IHACPA's Work Program, including the NHCDC and costing queries.

Equity and representation in data collection

IHACPA acknowledges that individual hospitals may undertake local initiatives to improve the accuracy of costing allocations for CALD patients. However, the collection and analysis of CALD specific costing data at a national level is currently constrained by the absence of consistent activity data definitions and capture mechanisms. Currently, IHACPA does not have plans to modify national costing processes in relation to CALD patient identification. All clinical and non-clinical costs related to patient care, including interpreter services, should be reported through the NHCDC based on the AHPCS Version 4.2.

The Australian Institute of Health and Welfare (AIHW) and the Department of Home Affairs are progressing work on inclusion of language data standards in the national health data set specifications to enable nationally consistent identification of interpreter support needs during healthcare provision. This will potentially facilitate consistent costing of language services in the NHCDC and support cost variation analysis.

Patient product reporting improvements

IHACPA has conducted a review of the NHCDC line items, cost centres and cost buckets to ensure consistent reporting across states and territories. Additional recommendations regarding the cost bucket matrix are welcomed and will be considered. IHACPA links costing data, including critical care and operating room costs, to the activity data submitted by states and territories, which includes ICU hours.

As part of this review, IHACPA is encouraging more granular reporting of pharmacy costs through the NHCDC cost centres. However, it is the responsibility of the states, and territories to ensure these products are costed accurately. Clinical pharmacy services in public hospitals should collaborate closely with their local costing departments to ensure that the costs associated with these services are accurately captured and reflected in patient-level costing processes, in alignment with the AHPCS and IHACPA's commitment to improving transparency and accuracy in healthcare costing.

IHACPA acknowledges the importance of clearly defined roles and responsibilities across states and territories, local hospital networks and hospitals. Recognising that states and territories are the system managers responsible for shaping, supporting, and coordinating local costing processes, IHACPA maintains regular engagement with state and territory health departments to address costing issues. This includes ongoing consultation through advisory committees to support consistent and informed implementation of costing practices.

6.2 Understanding recent growth in hospital costs

Question 18.

What potential areas of refinement could IHACPA consider to support the future sustainability and predictability of public hospital costs and funding?

Feedback received

Demographics and social health factors

AMAN recommended introducing a CALD cost adjustment or piloting a refinement to account for multicultural service needs. NSW echoed the importance of considering social health factors—such as homelessness, unemployment, and cultural diversity—as these factors influence hospital demand and cost. The Board of Treasurers (BOT) pointed to rising patient complexity, driven by demographic shifts, chronic disease prevalence, and social disadvantage, in explaining recent increases in the cost and intensity of care per admission. NSW also highlighted the importance of considering integrated care pathways, particularly for patients with complex needs, and suggested linking cost predictability with disease prevalence data.

Predictability of cost and emerging cost drivers and workforce challenges

NSW, SA, NT, ACT, HGSA, QNMU, the Rural Doctors Association of Australia (RDAA), CHA and BOT suggested a more forward-looking NEP, using recent cost data and time series analysis. SA proposed validating cost growth with the Australian Bureau of Statistics and Reserve Bank of Australia data and sampling cost data from selected hospital sites. NT suggested piloting inflation analysis in remote hospitals. HGSA supported health economic modelling to better track emerging cost drivers.

A stakeholder proposed multi-year price paths to enable predictability for hospitals and smoother integration of new technology. For example, setting a 3-year price roadmap for the NEP, where instead of a steep increase every July, there is a gradual increase of 2–6% each year.

Stakeholders raised concerns including rising living costs, medical expenses, and workforce shortages, especially among nurses and midwives. RDAA highlighted rural workforce challenges, and CHA noted regulatory variation as a factor affecting morale and system efficiency. ACT suggested that non-patient product costs could be considered in future models.

Qld advocated for recognition of long-stay patients in NEP calculations, particularly for multi-year mental health care patients.

Pricing model reforms

BOT highlighted additional structural cost pressures facing Australian public hospitals, including substitution of care from the private to public sector and escalating capital infrastructure costs. They called for major reforms to the pricing model including:

- establishing incentives for discharge ready patients
- considering options to improve data processing to reduce NEP lag where feasible
- developing proxy indicators and early warning systems for interim cost signals
- strengthening provisions to address inflationary shocks in a more timely manner and options to adjust for structural cost shifts
- greater alignment across pricing methodologies and Commonwealth funding policies e.g. reconsidering the 6.5% cap on annual Commonwealth funding growth.
- monitoring and exploring means to better capture the cost of capital and infrastructure in future pricing frameworks.
- mid-cycle or out-of-cycle pricing reviews

IHACPA's response

Demographics and social health factors

IHACPA notes that while there is interest in exploring pricing refinements for factors such as cultural and linguistic diversity and broader social disadvantage, significant challenges remain in the availability and quality of data to support such work. These limitations currently constrain IHACPA's ability to incorporate these considerations into the national pricing model.

Predictability of cost and emerging cost drivers and workforce challenges

As part of the National Efficient Price Determination 2026–27 (NEP26) development, IHACPA is analysing cost growth trends, with early indicators pointing to continued increases driven by workforce cost pressures. Ongoing analysis will also focus on workforce and cost-of-living-related costs, such as wage agreements and staffing models, and trends in activity and cost data to determine whether changes are sustained and explainable. IHACPA is not considering major changes to the national pricing model for NEP26 in this regard but will review this following the agreement of the next addendum to the National Health Reform Agreement (NHRA).

As part of the block funding review, IHACPA is in the process of exploring refinements to better account for long-stay patients, particularly for multi-year mental health patients. IHACPA acknowledges that a project led by Qld is underway to investigate the issues associated with long-stay older patients in more detail. IHACPA will consider the findings from this work as they become available.

Pricing model reforms

IHACPA notes the significant challenges in reducing data lag, particularly due to ongoing delays in state and territory NHCDC submissions under existing timeframes, and that streamlining data processing remains a longer-term aspiration. IHACPA will consider improvements to cost growth forecasting methodologies to support interim cost signal monitoring.

Under the NHR Act, IHACPA is required to determine a single NEP for each forthcoming financial year and is not permitted to revise the NEP mid-cycle or out-of-cycle in response to deviations from forecasted cost trends.

IHACPA notes that the 6.5% annual growth cap and capital costs being out-of-scope for NHRA funding are a matter for the parties to the NHRA. IHACPA will continue to provide independent, evidence-based advice to inform policy settings as requested.

Question 19.

What evidence, if any, is there to suggest that costs in categories such as labour and oncosts have increased since 2022–23 and will be reflected in future NHCDC cycles?

Feedback received

Enterprise bargaining agreements

Stakeholders including NSW, Qld, SA, WA, NT, AdPha, HGSA, and CHA cited new or updated enterprise bargaining agreements (EBAs) as key drivers of labour cost increases, especially in rural areas. NSW reported significant increases in average labour costs per encounter above the Consumer Price Index. NT described the high costs of recruiting and retaining staff, including housing and transport incentives. Qld referenced cost-of-living adjustments and anticipated wage growth. AdPha highlighted pharmacist-to-patient ratios increasing demand for specialised roles. HGSA and CHA pointed to general wage growth and minimum wage increases. CHA stressed funding models must adapt to rising labour costs to maintain service delivery.

Workforce shortages

SA, WA, NT, QNMU and BOT highlighted healthcare workforce shortages and increased reliance on agency and locum staff due to burnout and high turnover. QNMU, CHA, and SA emphasised that labour and on-cost increases are necessary investments in safe staffing and system resilience. SA discussed long-term trends in labour substitution with technology, the impact of clinical training requirements and recruitment challenges and rising costs in allied health. WA and NT noted high costs of attracting and retaining staff in remote locations. BOT emphasised that collaboration with the Australian Government is essential to develop long-term workforce capacity and mitigate future wage-driven cost growth.

Inflationary pressures

Stakeholders including Qld, SA, WA, NT and CHA linked rising labour costs to broader inflationary pressures. NT noted that wage growth was lagging inflation, contributing to increased reliance on agency staff, and Qld noted the unwinding of wage freezes as contributing to wage growth. WA and CHA noted that growth in base wages has driven up employment-related costs such as leave entitlements, superannuation, payroll tax, and workers compensation.

CHA, SA, NT and ACT proposed methodological improvements for future NHCDC cycles. ACT suggested comparing NHCDC data with Public Hospital Establishments submissions and EBA timelines. CHA recommended partnering with Jobs and Skills Australia for better workforce cost modelling.

IHACPA's response

IHACPA acknowledges stakeholder feedback on the significant and sustained increases in labour and on-costs across states and territories since 2022–23, and the implications these trends have for the NHCDC and NEP determinations. IHACPA notes that stakeholders have recommended integrating or comparing the NHCDC with other national datasets and this is an area IHACPA will consider for future collections.

IHACPA notes the key evidence and considerations referenced by stakeholders and will work with jurisdictions through its advisory committees on how these factors may be reflected in the NEP26.

To ensure future NHCDC cycles remain accurate and fit-for-purpose, IHACPA will:

- investigate the alignment of cost and expenditure data in the NHCDC and Public Hospital Establishments submissions, and consider how this data reflects EBA timelines, and other workforce cost indicators
- consider alternative ways to improve workforce and other cost forecasting and assess the expected impacts on the NEP
- consider additional cost collections in selected hospitals to assess more recent cost movements.

6.3 National Benchmarking Portal

IHACPA did not ask any specific consultation questions on the National Benchmarking Portal (NBP) but received feedback from NSW on this area.

Feedback received

NSW recommended the following changes to enhance the user experience and functionality of the NBP:

- provide state and territory level access to additional benchmarking data not available to the public
- make updates to reflect current national weighted activity unit (NWAU) and Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) Version 5.0
- add functionality to split by care type, same day and overnight episodes, and principal procedure splitting by Australian Refined Diagnosis Related Groups (AR-DRG) partition.

IHACPA's response

IHACPA plans to add an interface with state and territory level log-in to present more detailed benchmarking without masking low volume selections. This will be included as part of the next iteration of the NBP. Other suggestions will be considered, in consultation with advisory committees, for future iterations of the NBP.

6.4 Implementing recommendations from the Virtual Care Project

Feedback received

HGSA commented that virtual care is currently a well-established and frequently used model within genetic services and highlighted the importance of ensuring that virtual care in genetics is appropriately funded.

NSW expressed strong support for the recommendations of the Virtual Care Project and recommended that IHACPA develop a robust funding mechanism and pricing methodology.

Vic supported the recognition of virtual care costs but raised concerns about the complexities introduced when the provider incurring the cost is different from the provider reporting the activity. Vic further commented that state and territory governments contribute to public hospital funding beyond the scope of the NHRA, including infrastructure and technology, and these contributions should be factored into future pricing models.

RDAA emphasised the importance of ensuring that virtual care funding models accurately reflect the contributions of rural hospitals.

IHACPA's response

IHACPA is developing a work plan to address the recommendations from the Virtual Care Project report, in consultation with its committees and stakeholders.

A nationally agreed definition of virtual care is a critical enabler for progressing other recommendations. In 2025, IHACPA will support this foundational work through participation in the AIHW's Virtual Care Working Group. Agreement on a definition will underpin the inclusion of appropriate metadata and data variables in the associated DRS, enabling expanded data collection and improved costing practices.

IHACPA notes concerns regarding the complexities that arise when the cost-incurring provider differs from the reporting provider. Under the AHPCS, all relevant costs—including those associated with onsite and virtual care—must be allocated to the patient receiving the service. This ensures accurate reflection of costs in pricing models. IHACPA will continue to work with stakeholders on refining the activity collections for virtual care.

Regarding the feedback on funding public hospital costs beyond the scope of the NHRA, IHACPA cannot consider the inclusion of costs for elements that fall outside the scope of the NHRA in its pricing models.

6.4.1 Emergency virtual care data collection barriers

Question 20.
What, if any, barriers are there to collecting emergency virtual care (EVC) data submissions and how can IHACPA help jurisdictions to overcome these barriers?

Feedback received

CHA and ACT identified a lack of specialised data and reporting personnel as a major barrier to EVC data submission. ACT noted the clinical and administrative burden of additional documentation for virtual consultations.

NSW, Vic, ACT and PSA noted the challenge of integrating EVC data collection with existing digital health record systems and patient administration systems. Vic reported that EVC data is part of ED data and separating it for IHACPA submissions creates additional burden. Qld and WA reported no current barriers and are continuing to collect EVC data.

NSW, SA, ACT and CHA raised concerns about inconsistent or unclear data definitions, particularly around virtual care models and how they link to other episodes of care. ACT highlighted the need for clear guidance on triage categorisation and outcome coding. CHA noted misalignment between the DRS and the diverse models of care emerging from the rapid development of EVC services. As hospitals adapt to evolving healthcare needs, variations in how EVC is implemented may lead to differing interpretations of the data requirements, creating challenges at the state and territory level in aligning local practices with IHACPA's reporting expectations. NSW questioned the value of this data over current emergency care data sets, emphasising the need for early clarity on reporting requirements and definitions.

CHA, NSW, and Qld recommended tailored engagement with states and territories to assess readiness and support needs. NSW and Qld expressed general support for EVC data collection and pricing but emphasised the need for differentiated pricing models. Northern Health requested that a classification and price weights be established for virtual emergency department (ED) presentations.

IHACPA's response

IHACPA acknowledges the growing role of EVC services in public hospital systems and the importance of improving data collection to support future funding considerations. EVC data submission challenges identified by stakeholders will inform ongoing refinement of the EVC DRS and virtual care data development.

6.4.2 Refinements to the emergency virtual care data request specifications

Question 21.
What are some further refinement areas for the EVC DRS?

Feedback received

NSW, Vic, SA, NT, CHA and QNMU emphasised the need for clearer, national definitions and consistent application across states and territories, including for urgent care – especially in remote areas. They suggested aligning EVC definitions with existing datasets and revising scope statements to avoid duplication.

NSW, Vic, NT, ACT, and CHA recommended capturing the specific technologies used during virtual consultations—such as video, telephone, asynchronous messaging, and remote monitoring.

They further emphasised the need to differentiate between telehealth, virtual consults, and clinician-to-clinician models, as well as distinguishing standard from complex virtual care activities.

AMAN recommended culturally responsive virtual care funding models, including interpreter services and multilingual platforms.

Pharmaceutical Society of Australia (PSA) suggested additional EVC DRS refinement areas including of location (Modified Monash Model) of patient and hospital and, where care was triaged/referred to (if patient was not admitted to ED) and any follow up activity at the end of the episode of care, for example clinical handover.

IHACPA's response

IHACPA is actively contributing to the development of a nationally agreed definition of virtual care through its participation in the AIHW's Virtual Care Working Group. Once defined, IHACPA will focus on aligning EVC definitions and datasets—ensuring consistency with national collections such as the ED National Minimum Data Set (NMDS) and supporting robust data capture and pricing frameworks.

Through the data development work program, IHACPA will refine the EVC DRS to increase visibility in the national data collections. This will include exploring capturing virtual care provided by one emergency care facility to a patient who is physically present in another emergency care facility.

7

Future funding models

7. Future funding models

7.1 Trialling innovative models of care

Feedback received

The Independent Health and Aged Care Pricing Authority (IHACPA) did not ask any specific consultation questions on innovative models of care but received feedback on this area.

New South Wales (NSW) welcomed the opportunity to work collaboratively with IHACPA and other states and territories to investigate alternative funding models. Requested clearer guidance on the pathways available to establish and translate innovative models into longer term funding models.

Western Australia (WA) recommended that IHACPA lead the development of a streamlined process and practical guidelines to implement innovative models of care once the next addendum to the National Health Reform Agreement is finalised. WA also requested criteria that differentiates services that are in scope under innovative models of care and those under the General List Policy.

Catholic Health Australia and NSW called for strategic investment in innovative models of care, supported by interoperable digital infrastructure and alignment of hospital data with other national datasets.

IHACPA's response

IHACPA intends to develop a framework to provide greater consistency, clarity, and transparency, on the different funding mechanisms and translation of these models into long term funding arrangements.

8

Pricing and funding for safety and quality

8. Pricing and funding for safety and quality

8.1 Hospital acquired conditions and avoidable hospital readmissions

Question 22.
What, if any, are additional risk factors the Independent Health and Aged Care Pricing Authority (IHACPA) should consider in the risk adjustment models for hospital acquired conditions (HACs) and avoidable hospital readmissions (AHRs)?

Feedback received

New South Wales (NSW) and Western Australia advised that HACs are often not applicable to paediatric care and that the current risk adjustment models do not adequately reflect conditions relevant to paediatrics, leading to unfair penalisation of tertiary paediatric hospitals.

NSW, Catholic Health Australia (CHA) and the Queensland Nurses and Midwives' Union (QNMU) recommended incorporating patient characteristics such as:

- culturally and linguistically diverse (CALD) status
- Indigenous status
- socioeconomic background.

Queensland (Qld), South Australia (SA) and CHA proposed including risk factors reflecting:

- cognitive spectrum disorders
- clinical frailty measures like the Clinical Frailty Scale, Hospital Frailty Risk Score, and Frailty Related Index of Comorbidities.

Advanced Pharmacy Australia recommended accounting for polypharmacy and high-risk medications such as anticoagulants and chemotherapy.

NSW highlighted risk factors differ in virtual care settings such as increased falls risk at home but reduced infection risk due to lack of co-location.

NSW, Qld, SA, CHA, and QNMU raised concerns about incomplete clinical documentation, inconsistent coding and over-reliance on administrative data. They emphasised the need for:

- greater clinical input
- transparency in model development
- post-implementation reviews
- expert input from colleges and clinicians.

IHACPA's response:

IHACPA acknowledges the feedback received regarding risk factors in the adjustment models for HACs and AHRs. While formal post-implementation reviews are not currently planned, IHACPA welcomes analysis and feedback from states and territories to inform ongoing refinement of the models.

IHACPA's work program for safety and quality measures in the National Efficient Price Determination 2026–27 will focus on coronavirus disease 2019 (COVID-19) (including the suspension of temporary safety and quality measures for COVID-19 related episodes). Future work programs will explore geographic location (via remoteness), paediatric hospitals, indigenous status, cognitive considerations and frailty.

A lack of patient level data around CALD or economic status prevents IHACPA from including these risk factors in the adjustment models for HACs and AHRs. Pharmacy related risks are outside of the current HAC and AHR categories.

Clinical engagement will continue to be a core component of model development and validation. This will be supported through IHACPA's advisory committees as well as in collaboration with the Australian Commission on Safety and Quality in Health Care.

IHACPA remains committed to transparency, with technical specifications for the HAC and AHR models already published and publicly available.

Appendix A: List of stakeholders

The stakeholders that made submissions in response to the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2026–27 have been outlined below, except where respondents have been kept confidential due to commercial or other reasons.

Stakeholder	Abbreviation
Jurisdictions	
New South Wales Health	NSW
Victorian Department of Health	Vic
Queensland Health	Qld
South Australian Department for Health and Wellbeing	SA
Western Australian Department of Health	WA
Northern Territory Department of Health	NT
Australian Capital Territory	ACT
Organisations	
Advanced Pharmacy Australia	AdPha
Australian College of Rural and Remote Medicine	ACRRM
Australian Dental Association	ADA
Australian Multicultural Action Network Inc	AMAN
Australian Physiotherapy Association	N/A
Australian Society of Plastic Surgeons	ASPS
Australia's Cell and Gene Catalyst	The Catalyst
Board of Treasurers	BOT
Catholic Health Australia	CHA
Exercise and Sports Science Australia	ESSA
Gilead Sciences	Gilead
Human Genetics Society of Australasia	HGSA
Leukaemia Foundation	N/A
National Rural Health Alliance	NRHA
Northern Health	N/A
Peter MacCullum Cancer Centre	Peter Mac
Pharmaceutical Society of Australia	PSA
Queensland Nurses and Midwives' Union	QNMU
Rural Doctors Association of Australia	RDAA
The Royal Australian and New Zealand College of Psychiatrists	RANZCP
Townsville Hospital and Health Service	THHS

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